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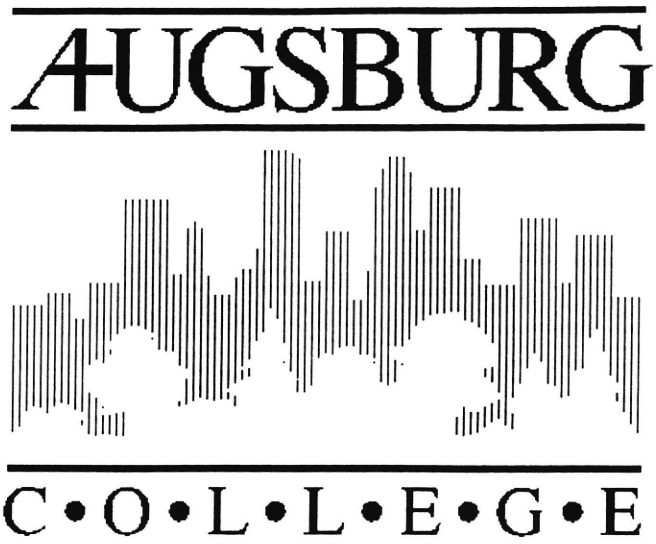
Observing Attachment Disorder in Adults

Aileen G. Ockwig
Augsburg College



MASTERS IN SOCIAL WORK THESIS

Aileen Gilbert Ockwig

Observing Attachment Disorder in Adults

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OBSERVING ATTACHMENT DISORDER IN ADULTS: AN EXPLORATORY STUDY

AILEEN GILBERT OCKWIG

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CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of :

Aileen Gilbert Ockwig

has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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Thesis Committee:

Thesis Advisor Sharon K. Patten, Ph.D.

Thesis Reader Anthony Bibus, Ph.D.

Thesis Reader Jacqueline R. Fendler, LICSW

ABSTRACT

OBSERVING ATTACHMENT DISORDER IN ADULTS.

AN EXPLORATORY STUDY

Aileen Gilbert Ockwig

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Mental health professionals who work with adults typically encounter clients who have issues left over from childhood. This paper discusses the Attachment Theory first conceptualized by John Bowlby and the therapeutic implications with adults concerning attachment theory based on psychoanalytic-object relations theory. Understanding and emphasizing the importance of affectional bonds with caring others is an essential part of treating adult clients with attachment issues.

The purpose of this study is to define the nature of the therapeutic relationship between client and clinician to identify therapeutic strategies that create a safe place for adult clients to explore issues of attachment, separation and loss. One hundred and twenty-five social workers who are in membership of the Minnesota Society of Clinical Social Workers were surveyed concerning therapeutic strategies, practices and techniques used to treat adults who present with attachment difficulties.

19 of the 125 surveys were returned representing a total response rate of 15 percent. Only 14 of which were returned completed, thus giving an overall usable response rate of 11 percent. From the data, many of the

respondents indicated that exploring the client's early object relations with his/her primary caregiver to be an important consideration when measuring the client's personality dysfunction and emotional maturity.

According to the data Psychoanalytic, Psychodynamics and Object-relations theories were the primary theoretical frameworks respondents used while working with adult clients who present with attachment issues. The concepts of transference and countertransference played an integral part in the therapeutic process when working with adult clients who have experienced attachment difficulties as children. Treatment practices concerning attachment dysfunction need to become standardized methods of treatment. In order to standardize treatment practices, more research needs to be conducted on a larger scale to increase awareness regarding therapeutic techniques, strategies and practices governing treatment with clients who have experienced attachment difficulties.

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I want to thank the Minnesota Society of Clinical Social Workers for participating in this study, my Thesis Advisor Dr. Sharon Patten for her guidance and wisdom, and most of all to God for his loving kindness, strength and faithfulness which gave me the ability to stay with this project unto completion.

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Definitions

In order to address the research questions, terms need consistent and measurable definitions. These terms are identified here in an effort to define key concepts found within the literature review.

Definition of Terms

Anomalous. Inconsistent with or deviating from what is usual, normal or expected.

Dyads. Two individuals (as husband and wife) maintaining a sociologically significant relationship.

Ethologist. A scientist who studies animal behavior and the formation and evolution of human ethos.

Introjection. To incorporate (attitudes or ideas) into one's personality unconsciously.

Ontogeny. The development or course of development of an individual organism.

Precocial birds. Capable of a high degree of independent activity from birth, for example: duckling.

Proximity. The quality or state of being very near or close.

Rhesus monkeys. A pale brown Indian monkey often used in medical research.

CHAPTER I

Introduction

The following study outlines the extrapolation of attachment theory traditionally applied to children in the therapeutic setting. It provides therapeutic suggestions and guidelines to practitioners dealing with adults manifesting ongoing attachment dysfunction while engaged in therapy with social workers, psychologists, marriage, grief, and family therapists.

Background of the Problem

Researchers historically have not focused much on the responses of adult clients concerning attachment issues. They have observed parents with their children with relation to attachment theory. Two instruments exist currently that measure adult response concerning attachment issues. George, Kaplan, and Main, (1984) created an instrument called the "Adult Attachment Interview" that established what type of attachment each adult interviewed experienced throughout his/her lifetime. Another instrument created by Mallinckrodt, Gantt, and Coble, (1995) determined an adult client's attachment to his/her therapist called the "Client Attachment to Therapist Scale" or "CATS". Again, the client was interviewed concerning his/her views about his/her childhood attachment experiences.

Statement of the Problem

Researchers have theorized that unattached children will remain dysfunctional as adults if untreated (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1973; Main, Kaplan & Cassidy, 1985; Hazan, & Shafer, 1987). Since many of these children grow up without treatment, attachment theory must be examined further in reference to the treatment of adult clients.

Purpose and Significance of the Research Study

This study explored therapeutic practices, strategies and techniques with clinical social workers treating adult clients presenting with a variety of problematic areas. The therapists indicated finding issues of attachment to be a primary concern for their clients. Therapeutic strategies, techniques and practices are presented which respondents reported utilizing within the therapeutic setting. The exploration of social work practice with adult clients in therapeutic setting contributes to the knowledge, skills and value base within the scope of social work practice.

This study also, contributed to one of social work's primary orientations in relation to treating persons in their environment. Social workers are often given primary roles as case managers and practitioners when assisting clients with difficult life events and adjustments such as relationship issues and loss.

According to Rubin and Babbie social work exploratory research is conducted for two main reasons 1) to begin to explore a new and/or underdeveloped area of social work practice. 2) to test the feasibility of further research or expand additional methods of research (1993). Currently, there is little research that explores attachment difficulties in relation to adult clients and the modes of therapeutic practices used to treat them. This study only begins to explore the research questions identified. Much more needs to be done in an effort to better understand the complexities of attachment theory and its influence on adult clients within the therapeutic setting.

This study was designed to be exploratory in nature. The sampling of respondents was purposive in order to facilitate the principal investigator's desire to ask local social workers to give their responses to key issues governing therapeutic practices with adult clients who presented with attachment difficulties. The principal investigator in an attempt to complete a masters level thesis was interested in the responses of colleagues already in practice.

Research Questions

This study addressed the following research questions.

1. What types of developmental limitations result in the childhood of a person who experiences attachment disorder?

2. What therapeutic techniques, strategies, and practices work well with adults who present with attachment issues?

Currently, this researcher leaves the historic perspective of attachment disorder to concentrate on the evolution of attachment disorder.

CHAPTER II

LITERATURE REVIEW

Historic Perspective of Attachment Theory and its Connection With Psychoanalytic-Object Relations

The literature reveals that attachment theory has evolved over several years (Ainsworth, Bell, and Stayton, 1974). John Bowlby became interested in developmental psychology while attending medical school. After graduation, Bowlby volunteered in a small behavioral school setting for boys. He worked with two young men who impacted him a great deal.

The first was an isolated, angry teenager who had never experienced attachment with a primary caregiver. The second boy was an anxious seven year old, who shadowed Bowlby everywhere he went to make sure Bowlby was nearby. Experience with these two children led Bowlby to further his education in child psychiatry and psychotherapy. While studying at the British Psychoanalytic Society, Bowlby conceptualized attachment theory (Ainsworth, Bell, and Strayton, 1974).

Attachment and Object Relations

Historically, attachment theory grew out of the object relations model, which itself originated from the Freudian psychoanalytic classical/drive structure model. Freud believed human subjects relate to external objects out of the need to satisfy two primary drives that are: a) the sexual or libidinal drive, and b) the aggressive drive of self-preservation. The type of

object is determined by the specific drive in operation (Greenberg & Mitchell, 1983).

Melanie Klein (one of Freud's contemporaries) worked with children and observed that children are not limited to relating to objects based on the above mentioned primary drives. Instead, she reported that at the age of six months infants begin to recognize objects around them and have the ability to internalize good and bad relations connected to the external objects in their world. Klein never actually abandoned the Freudian classical drive/structure model per se; however, in her writings she expanded Freud's theory to a much broader concept called the relational/structure theory of motivation. The concept of relational/structure theory maintained that subjects bond with others out of the need to reduce their primary drives for survival as infants and sex as adults (Greenberg & Mitchell, 1983).

Secondarily, people are dependent on others to meet their primary needs. Therefore maintaining a relationship with others is a secondary drive to meet the primary goal of survival and/or sex (Bowlby, 1978). Object relations theorists (Fairbairn, 1952; Balint, 1956; Winnicott, 1972) added to Klein's relational/structure theory and abandoned the classical drive/structure theory altogether, emphasizing the intrapsychic structures created as a result of the internalization of interpersonal relationships with specific others (Greenberg & Mitchell, 1983). The simplified definition of relational/structure theory, according to Greenberg and Mitchell (1983) is:

"individuals' interactions with external and internal (real and imagined) other people, and to the relationship between their internal and external object worlds" (Greenberg & Mitchell, 1983 p. 13-14).

Evolution of Attachment Theory

Psychoanalysts and learning theorists both agreed that affectionate bonds develop between individuals when one individual enlists the cooperation of another to help satisfy basic human needs. For instance, food in infancy and sex in adulthood require the need for assistance of another human being. This theory indicates two types of drives: primary and secondary. The need for food and desire for sex are considered primary drives, while the dependency of another personal relationship is considered a secondary drive (Bowlby, 1978).

In the 1930's several clinicians began to observe the ill effects of prolonged institutional care of children (Bender & Yarnell, 1941; Goldfarb, 1943; Skodad & Skeels, 1949; Spitz, 1946). Separation from their mothers also had a profound effect on the children at an early age. In 1949, Dr. John Bowlby accepted a position with the World Health Organization to study mental health issues of homeless children. Bowlby was eager to further his study of the adverse effects sporadic maternal care of children had on their children's personality development (Bowlby, 1982).

Subsequent to Bowlby's recommendation of how to minimize the distress of young people subjected to separation from their primary

caregivers, two films were produced that illustrated the plight of these young children. The film, *Grief: a Peril in Infancy,* (Spitz, 1947) followed by James Robertson's *A two-year Old Goes to Hospital* inspired the psychiatric community dramatically (Robertson, 1952).

The Contribution of Ethology to Attachment Theory

Attachment theory remained controversial for many years. Many psychiatrists, trained in traditional schools, questioned the validity of the theory, and pointed to a lack of evidence regarding the personality development of children (Bowlby, 1988).

Bowlby, a psychoanalyst, turned to the scientific principles of ethology and psychotherapy to further explore the personality development of humans. In object relations theory, dependency was considered a secondary drive engaged to meet the demands of the primary drives. Attachment theorists expanded on the notion of dependency as an instinctual behavior and/or personality trait. Additionally, they described the dependency behavior in terms of building a relationship with a primary caregiver out of a motivation to protect the self from emotional and physical danger (Bretherton & Waters, 1985).

Lorenz, an ethologist, provided the turning point for Bowlby's research with his study of precocial birds that indicated the bird's need and desire for comfort without any promise of food attached to the comfort. The study established that in the animal kingdom some of the species have developed a

strong bond with an individual mother-figure without the benefit of food. As with this species of bird, the young were not fed by their parents; they instead fed themselves by catching insects (Bowlby, 1988).

Harlow's study of the maternal deprivation of infant rhesus monkeys continued to support Bowlby's theory. Dr. Harlow found that the young primates maintained proximity with a dummy mother-figure as long as the dummy was soft and comfortable to cling to, despite the fact that the dummy did not feed the young monkey (Harlow, 1958).

Empirical Studies by Ainsworth

Ainsworth and Bowlby started working together in 1950. They poured over the literature in an effort to establish the link between personality development of young children and their lack of interaction with maternal caregivers due to long-term institutional care. Ainsworth conducted empirical studies both in the United States and Uganda, Africa to explore the link between mother and child bonds in relation to the personality development of the child. Ainsworth's studies created a strong base of evidence supporting the attachment theory (Ainsworth & Bowlby, 1991).

While in Uganda, Ainsworth conducted studies that provided the empirical data she and Bowlby needed to support their attachment theory. She assembled, with the aid of an interpreter, a sample of 28 mothers and their infants to study their interactions over a nine month time frame. She

observed the infants and their mothers approximately four hours every two weeks. She did not find data to support Freud's classical structure model which indicated human subjects primarily have two main characteristics of narcissism and passivity. Instead she observed how the infants related to their mothers as a secure base (Ainsworth & Bowlby, 1991).

The mothers appeared to be a secure base from which their children explored the world around them. An attachment was apparent when the children became distressed at the threat of and/or occurrence of separation from their mothers. Upon their mothers' return, the children would seek their mother's attention and stop crying when held by their mothers (Ainsworth & Bowlby, 1991).

The World Health Organization in 1962 filed another report describing the effects of the "deprivation of maternal care" on children. A report included a comprehensive article written by Mary Ainsworth. It addressed much of the skepticism by reviewing extensive evidence in support of the attachment theory (Bowlby, 1982).

Ainsworth launched another longitudinal study in Baltimore in 1963 with 15 mother-child dyads. Ainsworth hired a research assistant, Barbara Wittig, to assist with the study. Ainsworth and Wittig observed the dyads every three weeks from 3 to 54 weeks for about four hours each visit. In 1967, 11 more mother-child pairs were added to the study. At the end of the first year of life the baby and mother were introduced to a 20-minute

laboratory test known as the "stranger situation". The stranger situation study soon became instrumental in determining whether the interaction between mother and child represented a secure or insecure attachment (Bell & Ainsworth, 1972).

Findings from the "stranger situation study" indicated that mothers who were consistently sensitive to the needs of their children and responded promptly to any attachment seeking behavior, that is crying, and the desire for close contact, experienced secure attachments with their children (Ainsworth & Bell, 1969; Ainsworth, Blehar, Waters, and Wall, 1978). Bowlby suggested in his writings that close bodily contact between mother and child eliminated active attachment seeking behavior. Intense crying indicates the child's desire for close contact with his/her mother (Bell & Ainsworth, 1972).

Most often the mothers responded by holding the infants in their arms until the child stopped crying. Securely attached children stopped crying readily and reacted positively to being put down to the point of exploring their surroundings. Ainsworth concludes that appropriate close bodily contact does not create a spoiled, fussy, and clingy child (Ainsworth, 1979).

Patterns of Attachment and Their Determinants

Bowlby (1977) delineated four main patterns of attachment. The first, described as secure, resulted from the child's healthy interaction with his/her parental figure. A secure attachment was described as the consistent

healthy development of an individual who was confident his/her primary caregiver was available and responsive in any given situation. Children are often very curious and have the need to explore. Once the child has bonded with his/her primary caregiver, the child was free to explore his/her environment (Bowlby, 1977).

The second pattern of attachment, was called the anxious resistant or insecure-ambivalent attachment that happened when the child could not be certain his/her primary caregiver would be consistently available or responsive during difficult situations. Consequently, the child who was prone to separation anxiety tended to become anxious about exploring his/her world, clinging to his/her primary caregiver (Bowlby, 1977).

The third pattern, referred to as the anxious avoidant or insecure-avoidant attachment, meant the child did not have any confidence that the primary caregiver would respond to his/her need for comfort. Actually, the anxious avoidant attached child worried about being rejected when he/she engaged in attachment seeking behavior asking for comfort or protection. Children with an anxious avoidant attachment tried to live out his/her life without the support and love of others (Bowlby, 1977).

Finally, the last type of attachment, referred to as the disorganized-disoriented attachment was indicative of past traumatic events during childhood. Childhood traumatic events were evident when the child displayed inconsistent movements and contradictory behavior patterns. The

child appeared apprehensive toward his/her primary caregiver; exhibiting freeze-like, stilling, and dazed behaviors; similar to the adult post-traumatic stress disorder characteristics (Ainsworth, Blehar, Waters & Wall, 1978; Main & Solomon, 1990).

Bowlby (1982) conceptualized attachment as a behavior "with its own internal motivation distinctive from feeding and sex, and of no less importance for survival" (p. 35). He characterized attachment behavior as a form of behavior that results in a person attaining and maintaining proximity with another individual identified as his/her primary caregiver. The primary caregiver is described as someone who is able to give support whenever the person feels tired, frightened, sick and cares for the person regularly (Bowlby, 1977).

Characteristics of Proximity

Bowlby (1978) described the following characteristics of proximity which is the quality or state of being very near or close:

1. Specificity. Attachment behavior directed specifically toward a preferred individual.
2. Duration. An attachment generally lasts for a lifetime. Some attachments are severed altogether and/or strained during adolescence. However, early attachments are not easily forsaken.

3. Engagement of emotion. A person experiences his/her most intense emotions when forming and maintaining attachment relationships. The formation of a bond is similar to falling in love and maintaining a love relationship. The threat of loss becomes real as the person mourns the absence of the caregiver that brings about feelings of anger, emptiness and sadness.

4. Ontogeny. In most human infants, an attachment develops with a preferred individual in the first nine months of life. Continued social interaction with the preferred caregiver creates a stronger attachment with that individual. Consequently, the primary caregiver becomes the object of the attachment.

5. Learning. A key process in the development of attachment is the ability to recognize the primary caregiver from strangers.

6. Organization. An infant seeks proximity with the primary caregiver with a series of attention-seeking behaviors that promote proximity. These behaviors are organized according to the incorporation of representative models of environment and self. These behaviors are activated by certain conditions and terminated by others. Some activating conditions are hunger, fatigue, strangeness and anything that appears frightening. A child terminates attention-seeking behavior when the caregiver's presence is known.

7. Motivation of the attachment behavior is different and considered separate from both feeding and sexual behavior in human life. Dependency is not the same as attachment in that it is not directed toward a specific individual and does not infer an affectionate bond (Bowlby, 1978).

The Role of the Caregiver

Bowlby maintains there is a causal relationship between the attachment relationship and an individual's experiences with his/her parents to his or her ability to create and maintain affectionate bonds later in life. Marital problems, difficult parenting issues, depressive symptoms and personality disorders can be attributed to common variations of parental treatment. Parents who understand their child's need for security give respect to the child concerning that child's autonomy and respond to the child's attachment behavior (Bowlby, 1978).

In contrast, some children developed deviant patterns of attachment behavior because of inappropriate treatment by their parents. Bowlby listed some examples of parental inappropriate treatments of their children:

1. Rejection by one or both parents, unresponsiveness to their child's attention seeking behavior.
2. Deprivation of maternal care because of prolonged institutional care.
3. Parent threatens to withdraw love in order to control the child.

4. Parent threatens to abandon the child and/or spouse.

5. Parent blames the death and/or illness of the other parent on the child (Bowlby, 1978).

Characteristics of Maternal Caregivers

Mothers who participated in the Ainsworth "stranger situation" study share some common characteristics according to their own behaviors toward their infants. Mothers often interact with their children governed by the way they themselves were treated and/or taught to relate to others. Ainsworth lists the following types of attachment in relation to the characteristics of maternal caregivers, originally adapted from the "stranger situation" study depicted by Ainsworth (Ainsworth, & et al, 1978; Main & Solomon, 1990).

1. Secure infants. When characterizing mothers with Type B or secure infants the following attributes are present: mother's value attachment relationships with others and recall fond memories of attachment experiences they experienced as children with their own mothers, fathers or particular others. Given their positive attachment experiences these mothers were able to respond promptly to their own children's signals for proximity (Bretheron & Waters, 1985)

2. Insecure-avoidant infants. Mothers of type A or insecure-avoidant infants appeared insensitive to infant signals of attachment. The mother may

appear insensitive to the child's attachment seeking behavior in the following manner or being: 1) depressed therefore psychologically unavailable, 2) neglectful and unable to provide adequate care, 3) physically abusive and hostile (Egeland & Stroufe, 1981a, 1981b). Mothers also indicated both orally and behaviorally their dislike of close physical contact with their infants during the infant's first year of life (Main & Weston, 1982) Hall and Pawlby (1981) maintained that women who came from disruptive households were less involved with their infants. Researchers discovered that mothers who have experienced intervention from county child protective services concerning the parenting of their children are three times more likely to have been involved with a government child protection agency in the past as children (Rutter, Quinton, & Little, 1983).

3. Insecure-ambivalent infants. Mothers of type C or insecure-ambivalent children appeared preoccupied with the need for acceptance and assurance from their own parents. This type of mother has trouble maintaining structure and consistency with her own children. Consequently, the child never knows where he or she stands or what to expect next (Main, 1985).

4. Disorganized-disoriented children. Finally, mothers of type D or disorganized-disoriented children often have experienced the loss of their own parent early in life. These parents frequently have not been able to mourn the loss of their own parent. This is especially true when the

surviving parent is not able to talk about the death of the child's mother or father. The painful loss of their spouse made it difficult for the remaining parent to talk about or accept their spouse's death (Bowlby, 1980; Raphael, 1983; Main, 1985). Frommer and O'Shea (1973) found that mothers who reportedly had lost one of their parents prior to the age of 11 exhibited symptoms of depression.

Turning from the historical perspective of attachment disorder this study now reviews attachment disorder as it relates to adult clients currently.

CHAPTER III

THEORETICAL FRAMEWORK

Bowlby and Ainsworth conceptualized attachment theory as a framework for understanding the familial interactions that shape an individual's personality. Attachment theory describes a child's ability or inability to attach and/or bond to a primary caregiver. If a child is unable to bond or attach to a primary caregiver for a variety of reasons the child's attachment is considered insecure. A child with a secure attachment has experienced a stable continuous bond with his/her primary caregiver (Bell & Ainsworth, 1972).

Bowlby, a psychoanalyst, frustrated by the limitations of the object-relations theory turned to the theories of cognitive psychotherapy and ethology to explore personality development in humans. Bowlby believed the objects-relations theory was limited because of its primary emphasis on an internal relationship construct based on fantasy. He maintained that internal relationships are determined as a result of real-life events between children and their parents (Karen, 1990).

Several cognitive psychotherapeutic practices share with attachment theory the assumption that the relationship between client and therapist must be genuine to adequately facilitate the client's healing. Consequently, the union between therapist and client can be very effective. Transference enables the client to reconstruct the "balance between attachment-connection

and exploration-autonomy" (Biringen, 1994, p. 408). Genuine and congruent communication between the therapist and client is paramount. Genuineness is especially powerful when working with clients who have experienced insecure attachments as a result of a pseudo-affectionate caregiver.

Also, the client can begin to experience the comfort and security of a close relationship without the loss of self-boundaries with another person. The client has the ability to leave the relationship, without risking the loss of the relationship, thus gaining autonomy (Biringen, 1994). Time constraint does not allow for an explanation of each theoretical concept represented in psychotherapy. This researcher has chosen to discuss four modes of therapeutic practices in this paper as follows: Transactional Analysis, Gestalt, Bereavement and Family Systems Theory.

Transactional Analysis

While utilizing the Transactional Analytic (TA) theory, therapists maintain the assumption that people interact with others and self based on childhood experiences. Given the assumption that adults continue to conduct their lives based on the internalization of messages and interactions received early in life, therapists encourage clients to draw from childhood memories. Bowlby referred to this inner construct of expectations and attitudes formed by early attachment figures as "working models." Key elements when working with adult clients focus on the internalized representation of the attachment figure and the exploration of the influence of past experiences.

Both elements can be indicative of present relationships with the therapist and others (West, Sheldon, and Reiffer, 1989).

A number of key concepts employed by the TA therapist to help clients include: structural analysis, transactional analysis, role playing, family modeling and analysis of games and rackets (a series of negative feelings accumulated throughout life resulting from game playing interaction between child and parent over time), teaching and script analysis. The TA therapist empowers clients by helping them recognize and maintain behaviors that are presently serving them. The therapist helps the client recognize and correct ineffective behaviors (Steiner, 1974).

Clients are taught to recognize which ego state (parent, child or adult) is operating in a given transaction. According to TA theorists, games are designed to prevent messages, for example "you will never amount to anything." Initially games are created as a method of survival (Goulding & Goulding, 1979). Rackets are the combination of chronic negative feelings resulting from the games played by individuals early in life with their parents. Such negativity contributes feelings of guilt, anger, and depression to one's life script. The therapist assists the client in identifying defensive patterns, created early in life, to help his/her to correct earlier injurious attachment experiences (Steiner, 1974).

Role playing can be useful when an individual is having difficulty with one of the three ego states of TA. Another member of the therapeutic

system assumes the role of the ego state in order to facilitate communication between the self and ego state. Also, participants can practice with each other concerning changed behaviors and/or games to get feedback from other participants regarding behavior (McNeel, 1976).

Family modeling is a powerful method of working with structural analysis. The clients enlist the assistance of other members to help him/her to reenact a family dynamic. Discussion and evaluation following the exercise give clarity and significance to the original dynamic (Corey, 1992).

A series of interactions with his/her parents created early in life determines the clients' life script. Individuals determine life script in terms of destiny and worthiness according to the way they were treated as children (Berne, 1964, 1972). A central part of the client's self-concept and integrity related to the search for security in another person. Having the security of another person protected oneself from the danger of living alone.

A client with an insecure attachment has the following characteristics: 1) fear of rejection, intimacy and loss, 2) anxiety concerning availability and responsiveness of attachment figure often leads to the emotional distancing and rejection of others 3) proximity seeking and separation protest behaviors (West, Sheldon, and Reiffer, 1989).

Outlined in this paper are examples of therapeutic techniques gleaned from the Transactional Analysis and Gestalt theories. This writer chose to compare and contrast TA and Gestalt theories in this study because, many of

the therapeutic practices, techniques, and strategies are cognitive approaches similar to object-relations theory. When Smith and Glass (1977 reviewed over 400 studies measuring the effectiveness of 10 types of psychotherapies on average therapy clients. They concluded that eclectic, gestalt and transactional analysis therapeutic practices had the least therapeutic benefits of all the psychotherapies explored.

This paper does not specifically explore the relevance or effectiveness of Transactional Analysis and Gestalt theories in relation to other approaches of therapy. Exploring the effectiveness of different therapeutic theories needs to be examined in a future study.

Gestalt Approach

Gestalt techniques can be most helpful with clients who have minor to moderate life stressors and/or difficulties to work through (Yontef, 1987). Clients with a more complicated presentation, for instance, who have been diagnosed with severe personality disorders and/or psychoses often have limited success with Gestalt therapeutic techniques. Since many of the Gestalt techniques are fantasy based they can create confusion for clients who have been diagnosed with psychotic features (Shepard, 1970).

The Gestalt approach known as the here and now technique helps clients to identify personal responsibilities, recant direct experiences as opposed to talking about abstract experiences and helps them live in the here and now. A wide range of techniques are used in Gestalt therapy including

here and now, confrontation, dialogue with polarities, role playing, reversing roles, staying with feelings, exaggerating movements and reliving and re-experiencing unfinished business such as guilt and resentment (Corey, 1992).

According to Corey "the Gestaltist asks "what" and "how" questions but rarely asks "why" questions. In order to promote "now" awareness, the therapist encourages a dialogue in the present tense" (1986, p. 122). Corey identifies another "here and now" technique as follows " When the past seems to have a significant bearing on one's present attitudes or behavior, it is dealt with by bringing it into the present, as much as possible" (1986, p. 123).

The Gestalt therapist uses a technique called confrontation to promote a safe place required to generate attachment between the therapist and client and call attention to discrepancies in the client's thinking by asking how and what questions. Confrontation generally carries a negative connotation; however, used as a technique of Gestalt therapy it represents an invitation to the client for increased self-awareness. The therapist challenges clients to examine their thoughts, behaviors, and attitudes and to go beyond building defensiveness by avoiding and resisting therapy (Corey, 1986).

The therapist uses the technique of dialoguing to allow the client a way of recapturing aspects of his/her personality that he/she have denied or disowned. Therapists look for a split in personality function. Often there is a war between good and bad aspects of personality. These two aspects of personality are described as 1) the "top dog," a critical, authoritarian,

righteous, moralistic, demanding, manipulative and bossy parent. The critical parent bombards the client with "shoulds" and "oughts" and threatens devastating events. 2) the "underdog" manipulates by playing the role of the victim and appears to be a helpless, defensive, apologetic, powerless disobedient child. The critical parent and disobedient child are in constant battle for control. The disobedient child refuses to take responsibility, procrastinates and gives excuses for his/her action. The critical parent continually demands that the disobedient child conduct him or herself in a responsible manner. Both entities are fighting for their very existence (Corey,1986).

Gestalt's concept of introjection described above resembles Bowlby's concept of internal working model cited by Alexander as "a mental construction that forms the basis of the personality" (1992, p. 186). Gestalt uses the "empty chair technique" that allows the client to role-play both the "top-dog" and "underdog" by sitting in two different chairs each designated to be either the "top-dog" or "underdog". By talking on both sides of an issue or conflict the client gain's acceptance and is able to integrate painful parental introjects. Furthermore, the client can identify painful parental introjects (Corey, 1986).

Another way Gestalt therapy uses the technique of role playing occurs when the client is asked to reverse roles with a characteristic he/she normally does not display or has denied. Based on the premise of role playing it could

be useful for a therapist to ask the client to model the opposite of attachment disorder; which would be to play the role of a totally accepting and connected person. Pairing the feelings of attachment with continued practice to life events could serve as a helpful technique to assist clients to develop attachment behavior towards others. For instance, if a client normally maintains a positive outlook and gives others positive regard, that person would be asked to role model the complete opposite of that characteristic by becoming negative toward others. That same client would be able to dispel negative, resentful feelings and achieve a balance of positive and negative feelings in a more assertive lifestyle (Fagan & Shepherd, 1970).

Often during the course of therapy a client experiences painful feelings and finds it difficult to stay with the feeling. The therapist encourages the client to stay with and experience those feelings on a deeper level. Maintaining a deeper level of the pain enables the client to unblock and makes way for higher levels of growth (Corey, 1992).

People in everyday occurrences send out nonverbal messages that subtlety signal significant meanings. In order to enhance awareness of feelings a therapist may ask the client to exaggerate and repeat their physical movements, gestures and signals to intensify the feelings behind each meaning (Fagan & Shepherd, 1970).

Traditionally, dream work is considered to be a psychoanalytic technique. Gestalt therapy uses dream work for more than interpreting the

unconscious significance of a dream. Clients are encouraged to relive the dream as if it were happening in the present. The client is asked to give a list of details of the dream, remembering events, people, feelings, and is asked to participate in each role of the participants in the dream. Each participant in the dream is considered a "projection" of the dreamer. All of the different personalities within the dream are an expression of one's own inconsistent and contradictory sides. By expressing each participant's role the client can internalize and become more aware of his or her feelings. Perls suggested that "we start with the impossible assumption that whatever we believe we see in another person or in the world is nothing but a projection" (1969a, p. 67).

Whenever the therapist detects feelings of resentment in a session, it signifies unfinished business within the confines of the person's relationships. The clients then are asked to explore unfinished business of guilt and shame in order to complete unresolved feelings toward parents, siblings and friends, freeing the client from past unresolved issues (Fagan & Shepherd, 1970).

Bereavement Treatment

Working with bereavement issues is an important piece when considering individuals who have repressed feelings of loss over several years. Many adult clients who lost parents during the course of their primary years often have not had the ability to mourn that loss. A long term

state of mourning is one of the key characteristics of clinical depression (Klerman, et at, 1984). Ideally, healing of bereavement happens within a supportive family or friendly environment. Given the intensity and duration of attachment issues, individuals may not have close relationships upon which to draw (Biringen, 1994). Parkes (1987) suggests that there are many types of pathological grief and consequently several modes of treatment that can be effective when treating the bereaved.

Assessment of the bereaved encompasses many questions:

1. What are the circumstances surrounding the loss?
2. What was the previous relationship between the individual and the deceased person?
3. What type of support and encouragement to mourn is available from client's friends and family?
4. What other stressors exist during the time of loss ?
5. What types of previous unresolved childhood losses exist (Raphael, 1983)?

An assessment is useful when creating a treatment plan for working with clients who are grieving. A good treatment plan enables the therapist to create an outline to support clients who are in jeopardy of not resolving their grief. The treatment plan helps determine the appropriate mode of therapy with each client and assists clients in the resolution of their mourning (Parkes, 1987).

When treating clients with long-term bereavement issues regarding their attachment figure, the client is encouraged to describe the circumstances surrounding the death of their attachment figure. When the client's mourning is suppressed over many years, a pathological grief develops. The development of pathological grief is attributed to three main ideas: guilt feelings about the death of their caregiver, an inability to accept their attachment figure's death, and the client's fear of grieving. In an effort to break down barriers hindering the grief process, the therapist asks the client to discuss his/her relationship with his/her attachment figure repeatedly. Describing his/her relationship with his/her primary caregiver repetitiously avoids the inhibition, suppression and absence of the client's grief (Raphael, 1983).

Grief appears distorted when obsessive feelings of guilt and/or anger are present. Several things contribute to the client's angry feelings. The client had a dependent relationship with the deceased. The deceased died suddenly and unexpectedly due to a violent act, accident, or medical negligence. Guilt feelings are fostered when the client's relationship with the deceased was somewhat ambivalent. When a client is abused by the primary caregiver, he/she may secretly fantasize about the caregiver's death prior to the actual death thus the client is left with feelings of guilt. Finally "survivor's guilt" results when the client feels he/she should have died instead of the deceased.

The therapist's goal is to promote healing by encouraging the client to express unresolved grief, feelings of anger and guilt (Raphael, 1983). The therapist must explore feelings of loss and the relationship between the client and his/her attachment figure to better understand the ambivalent feelings and his/her connection with past parent-child relationships. The client may want to hold onto his/her guilt feelings in an effort to appease the deceased.

Chronic grief happens when the client is unable to resolve grief in an effort to keep the deceased with his/her because of a pathological dependence on his/her attachment figure. The client may experience secondary gain by controlling and punishing others in his/her grief, and eventually he/she may withdraw from caring support, including therapy (Raphael, 1983).

Re-grief is a system of reworking unresolved grief that explores two major themes: 1) to understand why the client has not been able to resolve his/her grief, and 2) to express grief presently. A detailed history is obtained concerning the deceased and the client's relationship with the deceased. Viewing a picture of the deceased during the session helps the client define clear boundaries between themselves and the lost person. The therapist focuses on personal objects of the deceased to assist the client in grieving. The interpretation of dreams during therapy is used to stimulate the mourning process (Parkes, 1987).

An existential approach to therapy is useful when working with bereaved clients. The Gestalt "empty chair" method can be used to resolve

issues of conflict with the deceased person. Another technique used by Gestalt involves "guided imagery" that enables the client to relive sequences of the loss by imagining scenes from the past. The client is asked to bring the scene into the "here and now" in order to reconstruct the scene and hopefully, to remove barriers to grieving (Melges & Swartz, 1989).

Historically, children have not been treated for grief for three main reasons: 1) Often, mental health professionals are not comfortable treating children with grief problems. 2) Therapists do not like dealing with death and 3) have inadequate rituals surrounding death to meet the needs of children. The therapeutic community believes that children are not severely affected by the death of their caregiver, and if they need grief therapy the surviving parent and/or family system would provide it for them. A surviving parent may be so caught in his/her own grief that he/she fail to recognize the child's need to grieve. Sometimes the surviving parent finds it too painful to discuss the absent parent and gives the impression to the child that it is not okay to talk about the deceased (Parkes, 1987).

Shared communication between family members promotes empathy, comfort and consolation towards each other that enables the family to eventually readjust their lives according to their loss. Such communication is fostered within the hospice movement brought about by the needs of families that have been touched by an acute or terminal illness of a loved one (Raphael, 1983). Family therapy with bereaved families emphasizes the need

for shared communication and feelings concerning the death and loss of a family member.

Family Systems

According to Nichols and Swartz the basic premise of the family as a system "is the context of human problems; and, like human groups, the family has emergent properties---the whole is greater than the sum of its parts" (1995, p. 62)

Family systems theory began evolving in the 1950's as hospital psychiatrists noticed that often patients who made positive changes within the hospital setting were unable to maintain those changes after returning to the home environment. Traditionally, family visits were discouraged to avoid disrupting patient therapeutic progress within the hospital setting. However, hospital practitioners observed that in families who were experiencing conflict and crisis the patient's improvements actually caused the situation to worsen. Thus, it appeared that the family needed to be treated together to avoid the deterioration of the patient's progress (Nichols & Schwartz, 1995).

Family therapists treat the family as one entity while considering the thoughts and feelings of the individuals represented by the system as a whole. The therapist facilitates change within the system by treating human problems by utilizing repetitive cycles of moves and countermoves in a circular fashion. The identification of family structures of triangulation,

boundaries and subsystems are useful when treating families systemically (Nichols & Swartz, 1995)

CHAPTER IV

METHODOLOGY

Research Questions

This study addressed the following research questions:

1. What types of developmental limitations result in the childhood of a person who experiences attachment disorder?
2. What therapeutic techniques, strategies, and practices work well with adults who present with attachment issues?

Research Design

The research design of this study was exploratory in nature. An exploratory research design traditionally does not examine hard data empirically however, merely enlightens the beginning observations of research and/or identifies the need for further research in a given area.

For instance, in this study question 2 can not be answered fully without consulting the adult clients, as well as, the social workers who treated them.

The survey was designed to enable clinicians to respond to questions regarding his/her treatment strategies, techniques, and practices he/she find useful when working with adult clients who have experienced attachment difficulties. A qualitative approach was used to evaluate participants' strategies, techniques, and practices used when treating adult clients in the

therapeutic setting. Units of analysis in the study were individual clinicians who practice therapeutic measures when treating adult clients.

Sampling Procedures

A purposive sample was implemented in the selection of participants. Purposive sampling was used, because the principal investigator resides in the Twin Cities Metropolitan area of Minnesota and needed to survey clinicians who conduct therapy with adult clients specifically for this study. Participants were social workers in membership of the Minnesota Society for Clinical Social Workers. The Minnesota Society for Clinical Social Workers have approximately 125 members, located in the Twin Cities Metropolitan area. While completing this master of social work thesis this researcher was especially interested in the opinions and experiences of clinical social workers within the metro area.

Instrumentation

The survey had standardized questions pertaining to demographic, mutually exclusive, ordinal data from clinicians in order to secure background data concerning each practitioner. The first section of the survey contained five questions relating to demographics and information regarding what type of settings the participants practiced in. Both open-ended and closed-ended questions were used to gather this information. The survey was grounded from information gathered in the literature review. This instrument was not based on any earlier surveys or research. The survey

asked what primary theoretical framework clinicians ascribed to in their therapeutic settings with clients.

The next section included ten open-ended questions regarding the therapists' methods of therapeutic practices, strategies and techniques used when treating adult clients who present with attachment difficulties. The survey included a brief outline of each type of attachment and its characteristics which gave the clinician an understanding of what was meant when the survey referred to the attachment theory. The surveys were expected to take participants approximately 30 minutes to complete.

Data Collection

This investigator contacted the director of the Minnesota Society for Clinical Social Workers via telephone, and explained the scope and purpose of the study. The investigator stated that the Minnesota Society for Clinical Social Workers was selected as a sample because it meets the criteria for the purposes of this study. The investigator requested a list of members of the Society in order to send questionnaires to gather information for the study.

The director expressed an interest in the attachment theory study, then met with the membership committee to discuss the investigator's proposal. Once permission was secured from the committee the director agreed to send the investigator the list of the Social Workers in current membership of the Minnesota Society for Clinical Social Workers.

One hundred and twenty-five surveys were mailed out to clinical social workers who are in membership of the Minnesota Society for Clinical Social Work. In May of 1996, questionnaires were sent out to the clinicians and they were given a two week window of opportunity to respond. A letter of consent accompanied the questionnaires, outlining any possible benefits, risks or expectations of the participants. Given time constraints a follow-up letter was not sent to increase participation.

Human Subjects

Ethical protections were employed to protect human subjects and to minimize risk. One procedure for the protection of human subjects included an expedited review and approval from the Institutional Review Board at Augsburg College. A consent letter was mailed with the survey, respondents were informed that returning the survey would serve as their consent to participate in the study. In order to ensure anonymity the following steps were taken: a) A colleague adhered address labels to the materials and sent them out to each clinician b) Each clinician was asked not to include any identifying personal data. c) Return addresses were not indicated on the letters of response, so there would be no way of knowing which clinicians responded to the survey. d) The clinicians were informed they could refuse to answer any question or questions on the survey without being dropped from the survey or experience any impact on their affiliation with Augsburg College and/or the Society of Clinical Social Workers.

CHAPTER V

RESULTS

This chapter presents the results of the study. Initially the chapter gives demographic data concerning the participants. It is then organized according to the research questions within the framework of attachment theory.

Respondent Information

One hundred and twenty-five surveys were mailed out to clinical social workers who are in membership of the Minnesota Society for Clinical Social Work. 19 of the 125 surveys were returned representing a total response rate of 15 percent. Only 14 of which were returned completed, thus giving an overall usable response rate of 11 percent. Since 4 percent of the respondents were no longer in practice and/or did not work with adult clients in their practices, they declined to complete the surveys citing the inability to give appropriate answers.

All of the respondents were licensed clinical social workers (LICSW), three of which carried additional licensures including licensed marriage and family therapist (LMFT), licensed psychologist (LP) and certified chemical dependency practitioner (CCDP) All of the respondents work with individuals and couples in therapy. Ten of the 14 respondents indicated they

work with children and families. Only 7 of the 14 respondents reported facilitating group therapy within their practice.

Research Question #1

What types of developmental limitations result in the childhood of a person who experiences attachment disorder?

Identification of Attachment Issues with Adult Clients

Respondents were asked how they identify adult clients who present with attachment disorders? When questioning clients regarding potential attachment issues that may have arisen in childhood, five of the fourteen clinicians surveyed cited several relevant indicators used to diagnose clients. Among these were poor relationships, multiple societal problems, failure to take on adult tasks, depression, isolation, ongoing chronic stressors, lack of intimacy, persistent unhappiness, no friends or desperate lonely quality of friendships. Nine respondents reported the necessity of taking extensive social and family histories of individuals during initial visits with their clients.

When exploring the family history, 8 of the respondents reported paying close attention to client's primary relationships with their mothers, fathers and spouses to determine level of relationship functioning. Ongoing chronic severe stress, disease, dysfunction in the client's history with a

significant person (e.g., parent, child, sibling, etc.) signifies attachment issues early in life.

Five of the respondents identified traits of persistent unhappiness, lack of intimacy, and isolation as indicators when determining clients who have attachment difficulties. Twelve of the respondents assessed the character, quality and dynamics of early relationships. One of the respondents eloquently stated "that the influences of these relationships on current functioning gave important information regarding the clients developmental mastery and personality formation". While four additional respondents indicated agreement with the above statement using different verbiage.

Three respondents suggested that present day difficulties within client relationships can denote attachment issues early in life. Early and current relationships often appear very similar, which in turn, can be attributed to the client's learned survival skills. At one time, such survival skills may have been very useful when resolving conflicts and preserving relationships. One respondent stated that "many of the survival skills learned as children can be toxic in current relationships with a spouse and/or significant other". An examination of past and present relationships can help the clients understand their old survival skills and re-evaluate their purpose and application to current relationships.

Two of the respondents disclosed what clientele they predominantly worked with. The first respondent reported working with Vietnam veterans diagnosed with Post Traumatic Stress Disorder (PTSD). He/she also indicated in his/her practice that several of his/her clients who have been diagnosed with PTSD have experienced poor attachments with their primary caregivers as children. The other explained he/she worked with teenage mothers. He/she stated his/her clients reported a lack of connectedness with their own primary childhood caregivers which inhibited their ability to bond with their own infants.

Two of the respondents said that "exploring the clients' functioning, regarding early object relationships were an important part of diagnosing adult clients who presented with attachment difficulties". Five of the fourteen respondents maintained that, understanding the client's early object relationships helped the clinician measure personality dysfunction, emotional maturity, developmental mastery, and helped determine if attachment issues were present.

One respondent gave specific indicators used when assessing adult clients who have experienced attachment difficulties early on. These indicators include the degree of autonomous ability, separate identification, sense of separateness, self-esteem, capacity for love of others, ability to tolerate loss/separation, ability to appraise needs of others versus project needs onto others, and the degree of isolation, citing few or no friends, or

client's friendships having a desperate and lonely quality. Also, he/she reported that clients complained of never feeling connected to others.

Similarities and/or Dissimilarities of Client Symptomology

Next, respondents were asked if they found any similarities and/or dissimilarities in client symptomology according to the following characteristics: gender, race, culture, birth order, mental and physical health client as a child or the mental and physical health of the client's parent.

Three respondents did not answer questions pertaining to gender. Two respondents stated men are less likely to explore and identify their feelings. One respondent reported he/she only worked with men. Two respondents reported men seem to present with more angry acting out, while women appeared needy and clingy. Another respondent indicated women present with more narcissistic issues and depressive symptoms than men. The therapist who indicated he/she worked with teenage mothers stated having seen many mothers who experienced parent/child difficulties with their own children related to insecure attachment in childhood. The mother's insecure attachments manifested in their children ages 1-4 years having problems with separation, individuation and autonomous tasks. One respondent reports men are more guarded and have problems with impulse control as adolescents and conduct disorders as men. One respondent stated that only women clients appear to be compulsive caregivers.

Eight of the respondents did not answer questions pertaining to race, 5 of which indicated they have limited diversity in their practices, therefore unable to comment regarding similarities or dissimilarities pertaining to race. One respondent answered yes, he/she believed the client's race had an impact the similarities and/or dissimilarities of attachment dysfunction, without explanation. Three respondents indicated minority clients tend to be more damaged, frustrated, and had underpinning issues of anger. Two respondents indicated Native and African Americans tended to be less open in a therapeutic setting.

Eight of the respondents did not answer questions pertaining to culture. Three respondents answered yes, they believed culture may affect similarities and/or dissimilarities pertaining to childhood attachment dysfunction, but gave no explanation. Another respondent reported that cultural and language differences created barriers in determining the appropriate diagnosis. One respondent identified persons growing up in single family homes as having a cultural perspective to be considered, often affected by the amount of extended family involvement. One respondent reported that within the African American community there seems to be a high rate of male abandonment, thus increasing the number of African American clients with attachment difficulties.

Nine of the respondents did not answer questions in relation to birth order. One respondent reported first born children appeared to be more

anxious. Another respondent characterized the oldest child as intellectual and aloof, the middle child more emotionally sensitive and the youngest child more clingy. One respondent indicated the middle child would be more likely to have attachment issues. Another respondent depicted the oldest child having a tendency towards caretaking, while the youngest child generally has a tendency towards dependency on others, consequently having more issues with attachment difficulties.

Two respondents did not answer questions regarding the mental and physical health of the client's parents. Ten of the respondents acknowledged there is an association between the mental and physical health of the child's parents and the effects on attachment dysfunction. One respondent reported that adult clients caring for chronically ill aging parents will present with attachment problems. One respondent reported that parental problems with mental and physical health increases the likelihood of ambivalent/avoidant attachment issues. For instance, clients who had parents who were depressed or borderline may have poor physical health.

Three respondents gave no response to questions pertaining to the mental and physical health of the child. Eleven respondents agreed the mental and physical health of the child relates to the attachment dysfunction in marital relationships and impacts how the client sees him/her self.

Ten respondents did not give additional characteristics to consider. Additional characteristics were reported as follows: One respondent indicated

that parents who have a difficulty with separation and disconnection issues with their own children often stem from having multiple caretakers themselves during childhood. One respondent implied that sexually abused adults (as children) have significant issues in therapy. Another respondent indicated that biological predisposition to certain mental illnesses have a tendency to emerge as risk factors contributing to client attachment issues. Finally, one respondent reported that faulty attachment experiences result later in serious problems with personality such as narcissism, borderline, and antisocial.

Research Question #2

What therapeutic techniques, strategies, and practices work well with adults who present with attachment issues?

Beginning Therapeutic Techniques

Respondents were asked how they begin therapy with adult clients they diagnosed as having attachment issues. Four of the respondents failed to state how they began working with adult clients who presented with attachment issues. Three of the respondents indicated transference as a key component when working with adult clients. One respondent indicated that developing a rapport with clients beneficial when creating a safe haven, thus enabling clients to work on attachment issues. One respondent indicated that separating past from present experiences is necessary when working with clients focusing on current relationships. Another respondent

indicated that helping clients identify attachment issues and their meaning to the clients is helpful in establishing an alliance of trust with the clients. One respondent gave specific ways to treat clients with attachment issues. The respondent reported using an advanced method of confrontation and achieving a higher trust level with clients who experienced secure attachments as children. When working with a client who experienced anxious attachment in childhood the same respondent indicated implementing "consistent care" that employed self-approval and being vigilant regarding approval seeking behavior. For the client who experienced an avoidant attachment during childhood again the same respondent used "careful confrontation", "empathy" and "here/now" techniques. With the client who experienced a disorganized type of attachment in childhood the therapist set firm limits using "empathy" and "here/now" therapy.

Respondents were then asked what primary theoretical framework they use when treating adult clients who have experienced difficulties with attachment issues.

Primary Modes of Therapy

Four of the respondents indicated "Psychoanalytic" as their primary theoretical frame of reference, two of which, indicated using "ego centered therapy" in addition to the Psychoanalytic approach. While four more respondents indicated a more modern version of psychoanalytic theory, by indicating, "the psychodynamic theory" as their primary mode of treatment

with adult clients who present with attachment difficulties. Only one of the respondents identified the family systems theory as his/her primary mode of therapy used when working with adult clients. Five therapists reported using "object-relation theory" when working with adult clients with attachment issues, two of which, indicated using "insight therapy" and "cognitive restructuring" as beneficial when working with this population.

Respondents were asked what different treatment techniques, practices and strategies they use when working with adult clients who present with attachment issues. Four of the respondents gave no additional information regarding treatment techniques, practices and strategies. Four of the respondents indicated transference and countertransference as important items to consider with working with this population. Two therapists indicated using here/now techniques with adult clients who present with attachment difficulties. One therapist indicated using dream analysis was beneficial when working with this population. Gestalt used both here/now and dream analysis techniques in his work with clients (Corey, 1986). Another respondent used confrontational techniques when working with clients who were functioning at a neurotic level. Gestalt used confrontational methods of treatment when working with clients (Corey, 1986). One respondent stated "unattached adults like children, say more with their behaviors, than their words." Finally, the last respondent states the importance of listening intently to this population, because persons with

attachment issues generally are not likely to be overt in their initial presentation. One respondent cited using the importance developing a connection with clients who have experienced ambivalent attachments as children.

CHAPTER VI

DISCUSSION AND CONCLUSIONS

Characteristics of Developmental Limitations

Fourteen of the participants in this study acknowledged that several of their clients have primary concerns around untreated attachment difficulties left from childhood. The respondents answered questions regarding techniques and strategies adapted when assessing and treating clients with attachment disorders.

From the literature (Bowlby, 1980; Raphael, 1983; Main, 1985) this researcher concluded that clients who exhibited over-determined pseudo-independence would be characteristic of a disorganized-disoriented attachments. Clients who display inappropriate dependence on others would be classified as having anxious-ambivalent attachments. Anxious-ambivalent, insecure-avoidant and disorganized-disoriented have common features of adult attachment styles applicable when diagnosing Axis II personality disorders i.e., Narcissistic, Borderline, Obsessive Compulsive disorder, and Anti-Social personalities (Bowlby, 1980).

In the literature Bowlby implied that children who were hospitalized for any length of time were less likely to experience a healthy attachment to their parents (1982). One respondent reported believing that attachment disorder is the major issue of our time. Another respondent stated that early

childhood treatment and family intervention are crucial in the prevention of faulty attachments.

The respondents answered the questions regarding assessment and treatment more readily than questions regarding additional characteristics. The information regarding assessment and treatment was much more bountiful than the discussion surrounding additional characteristics such as gender, birth order, mental and physical health of the parents, and mental and physical health of the child.

Gender

Five of the respondents indicated boys having attachment difficulties have problems with impulse control while girls have problems with narcissistic behavior and depressive symptoms from adolescence to adulthood.

Birth Order

From the data four respondents related to birth order as follows: the oldest child was characterized as being more intellectual and aloof with a trend toward caretaking while the middle child appeared more emotionally sensitive. Finally, the youngest child was reported to be more clingy with a trend toward dependence.

Mental and Physical Health of the Parent

In the literature Bowlby (1978) and from the data, one of the respondents indicated that parents who were not emotionally available to their children for a variety of reasons such as: self-indulgence, over-reliance on technology, mindless consumerism, careerism, material greed, illness, death, depression and/or other mental health diagnosis contributed to the attachment disorders of their offspring.

Mental and Physical Health of the Child

In the literature Bowlby implied that children who were hospitalized for any length of time were less likely to experience a healthy attachment to their parents (1982).

Treatment Modalities

Three of the respondents disclosed being successful with "here and now" and confrontive techniques when working with adult clients who have attachment difficulties. Both of the techniques were mentioned in the literature review under the *Gestalt Approach and Bereavement therapies.* From the findings confrontive techniques are helpful when working with adult clients who exhibit acting-out behaviors common among unattached adult clients, because adult clients, like children, say more by exhibiting behaviors than with their words. In therapy clients sense feelings of connectedness with their therapist known as transference.

According to Biringen, transference enables the client to reconstruct the "balance between attachment-connection and exploration-autonomy" (1994, p.408) Transference issues reveal how clients relate to their therapists by building trust or exhibiting a continued lack of trust. Transference and counter-transference played an important role when assessing adult clients who have experienced attachments disorders. One of the respondents disclosed feelings of being smothered, dismissed or jerked around to be prime indicators that clients most likely had attachment issues. The therapists found transference to be a useful tool which helped them enlist the trust and connectedness of their clients.

Primary Therapeutic Practices

From the findings respondents indicated the most widely used therapeutic practices used with adult clients who presented with attachment disorders were psychoanalytic, psychodynamic, object relation, family systems, here and now, confrontive, cognitive re-structuring, and/or insight therapy. Respondents disclosed that often they think in developmental terms when working with clients enabling them to respond to clients in an appropriate empathetic manner. Confrontive techniques are helpful when working with clients who exhibit acting-out behavior common among unattached adult clients, because adult clients, like children, say more by exhibiting behaviors than with their words (Corey, 1992). In the data one of the respondents who reported working with clients who have been diagnosed

with PTSD stated listening to his/her clients more attentively in order to pick-up subtleties is important since clients with attachment disorders are less likely to be direct. While another respondent reported the same phenomena while working with adult clients who present with attachment issues.

The respondents discussed the use of transference with clients to experience and interpret their clients' attachment disturbances in an empathetic manner. In the findings respondents confirmed that clients present a unique inner world in which other relationships in the form of projective identification generally get projected on the therapist, as in the object-relations theoretical framework outlined by (Balint, 1956; Fairbairn, 1952).

According to the object-relations theoretical framework Greenberg and Mitchell (1983) stated that object relationships are defined when children begin to recognize and internalize good and bad relations connected to the external objects surrounding them. Bowlby, (1978) identified the most important external object in a child's world is his/her primary caregiver. The therapist then responds to the projected material in order to present a healing context that is often unlike how their clients were treated in childhood. Use of therapy as a tool is employed to add insight and understanding to current relationship problems that may be rooted in earlier attachment disturbances.

Three therapists indicated the use of "here and now" and confrontive techniques with clients. Both techniques are well-known among Gestalt therapists. Confrontive and here and now techniques are primary functions of re-grief therapy as well, mentioned earlier in the literature review. Grief therapy is helpful when working with clients who present with disorganized-ambivalent attachments. Often clients that have been diagnosed with disorganized-disoriented types of attachment have experienced significant losses early in life (Bowlby, 1980; Raphael,1983; Main, 1985). Treatment with this population was described by one respondent as being comprised of the following elements: setting firm limits, being empathetic and using the here-and-now technique.

In addition, the respondents outlined therapeutic practices used with other attachment disorders. From the data respondents used a more advanced method of confrontation with securely attached clients, counting on a greater level of trust between therapist and clients. Finally, the respondents described therapeutic practices with the anxious-ambivalent clients as consistent, emotionally available, careful to emphasize self-approval over seeking the approval of others, again being empathetic and using the here-and-now technique adapted from Gestalt therapeutic practices (Corey, 1986).

Conclusion

Therapeutic practices are so subjective that they are difficult to measure. Often therapists are hard pressed to report how they do practice with clients because therapy is such a creative science. Many therapists consider themselves as eclectic practitioners using a variety of techniques, practices and strategies adapted from several sources, not subscribing to only one school of thought or practice. What works with one client may not with another. Therapists are continually trying new techniques. Asking a therapist to describe how he/she works with clients is much like asking an artist to explain his/her techniques used when painting an abstract piece of art.

The attachment theory has many components including the patterns of attachment, characteristics of proximity, the role of the caregiver, and the characteristics of the maternal caregiver. The Attachment theory can be a powerful tool to help therapists understand and treat a sometimes mysterious and challenging population (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1978; Main & Solomon, 1990).

Limitations of Study

The sample size did not allow for statistical significance. Unfortunately with the low response rate of respondents it is impossible to project how those who did not participate would have responded to the

questions. Only clinical social workers were surveyed; consequently the study did not represent other professionals who routinely work with the same clientele in therapy, adoption, law enforcement, schools, etc. All of the respondents resided in the same geographical area, therefore limiting the ability to generalize to a larger population.

None of the respondents indicated their answers were influenced by their own research and/or research findings of another practitioner. Consequently, not knowing if the respondents answers were guided by previous research the validity of this study was compromised. The survey was limited in that it was not pre-tested allowing the researcher to consider other's opinions concerning the validity of the instrument used.

The study was limited in that the questions were not very explicit in nature. It would have been easier to compile the data if the respondents had been given a set of answers from which to choose. Implementation of a Likert scale would have simplified the surveys both for the respondents and the researcher. Many of the respondents unknowingly gave information not pertinent to the survey and found it difficult to answer items because the survey appeared too vague. Consequently, many of the answers given were also too vague to pertain to the study.

One respondent stated in response to a question about similarities

and/or dissimilarities in client symptomatology that it would have been helpful to have been given some examples of similarities and/or dissimilarities.

Often, it is difficult for therapists to discuss what types of therapeutic strategies, techniques, and practices he/she uses with clients. Many therapists hone their skills by trial and error over several years finding it difficult to describe what works when with clients.

Upon completion of this research, this researcher would conduct new research in a much different context: 1) Identify and use therapists who routinely work with clients who present with attachment difficulties. 2) Randomly assign clients to either the experimental group or the control group. 3) Enlist the therapist's cooperation in monitoring clients' progress over a six-month time frame concerning key concepts. 4) The importance of transference and countertransference in therapy should be noted. 5) The application of techniques from the object relations theory of treatment should be applied, to the experimental group. Monitor and implement techniques from the TA and Gestalt treatment practices with the experimental group and record specific treatment modalities and their impact on each of the clients, thus making the study more tangible.

Future Research

A great deal of research and information outlining what the phenomenon of attachment theory is available as it relates to children.

However, little is written about the different treatment methods therapists use to treat both children and adults who have issues with attachment difficulties. There are several modes of therapeutic practices therapists implement while working with clients in a therapeutic setting. Research comparing the different modes of therapeutic strategies, practices and techniques therapists use with clients would be helpful in the standardization of mental health practices.

It is this writer's opinion that the mental health field is entirely too abstract in the implementation of therapeutic practices with clients. Without the standardization of therapeutic practices it is difficult for clients and/or consumers to discern whether or not the therapist they choose will or can be helpful to them. It is also, difficult for clients and/or consumers to choose a therapist that understands and has the ability to work with the clients' specific issues.

Implications for Social Work Practitioners

Therapists and social workers are becoming increasingly aware of adults who have experienced attachments difficulties. This researcher recently attended a workshop on attachment issues comprised of mental health professionals from a variety of disciplines. Several participants worked in law enforcement, some from adoption agencies and others were individual therapists all concerned about the next generation and the serious

problems that occur when clients have suffered attachment difficulties early in life.

The law enforcement professionals maintained that there are several societal problems stemming from poor attachment experiences of children such as truancy, juvenile delinquency, substance abuse, neglect of children and domestic violence. There are an increasing number of adults who have experienced attachment difficulties as children and will not be able to break free from future societal problems without the help of dedicated astute professionals armed with the ability to treat this pervasive population.

Therapists need to be able to recognize and treat attachment disorders. Continuing education credits need to be offered to social workers who work in adoption agencies, along with doing individual therapy with adult clients. Other professionals such as psychologists, nurses and law enforcement workers need to make treatment of attachment dysfunction commonplace in therapeutic practice sites. Information regarding treatment practices need, to become more readily available to therapists who work with adult clients who have experienced attachment difficulties as children and who continue to have relationship problems as adults.

Treatment practices concerning attachment dysfunction need to become standardized methods of treatment. In order to standardize treatment practices, more research needs to happen on a larger scale to increase awareness regarding therapeutic techniques, strategies and

practices governing treatment with clients who have experienced attachment difficulties. At this time treatment of children who have experienced poor attachments early in life is still controversial. This researcher believes they will remain controversial as long as such practices are not fully understood by more than a handful of practitioners who specialize in treating children with attachment problems.

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IMPLICATIONS OF ATTACHMENT THEORY AS IT RELATES TO THERAPEUTIC PRACTICES WITH ADULT CLIENTS.

A. Background information. Circle all that apply.

1. What is your level of licensure?
    1. LICSW
    2. LCSW
    3. LGSW
    4. LMFT
    5. Please specify any licenses not listed _____.

2. Do you work for an agency?
    a. yes
    b. no

3. IF YES, what type of agency is it?
    a. public non-profit
    b. private non-private
    c. private for profit

4. Do you have a private practice?
    a. yes
    b. no

5. IF YES, is your private practice?
    a. full-time
    b. part-time if so, how many hours per week ____.

B. Therapeutic Practices with Adult Clients.

6. What type of clients do you work with in your practice? Circle all that apply.
    a. Individuals
    b. groups
    c. couples
    d. family
    e. children
    f. other please specify _____.

7. How do you identify adult clients who present with attachment disorders?

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. For each category below, explain in as much detail as you can how you proceed with someone you diagnose with attachment issues:

8a. The primary theoretical framework you use when working with adult clients who have experienced difficulties with attachment issues.

8b. The different treatment techniques, practices, and strategies you use when working with adult clients who present with attachment issues?

8c. Do you vary treatment techniques, practices and strategies based on the type of attachment issues the client presents? If so, please explain:

8d. Have you noticed any similarities and/or dissimilarities in client symptomology according to the following characteristics? If so, please explain.

1. Gender

2. Race

3. Culture

4. Birth Order

5. Mental and physical health of the client's parent.

6. Mental and physical health of the client as a child

7. Other characteristics, please specify.

9. Please add any comments or thoughts you have regarding the survey or practice with adults clients who present with attachment disorders.

Thank you so much for participating in this survey. Your responses will serve to further the research necessary to help these individuals.

Please do not write any identifying information on the questionnaire or return envelope.

MINNESOTA SOCIETY FOR CLINICAL SOCIAL WORK

Generating Excellence in Clinical Social Work

3141 Dean Court, #C1101
Minneapolis, MN 55416

February 29, 1996

Dr. Rita Weisbrod
Institutional Review Board Chairperson
2211 Riverside Avenue
Minneapolis, MN 55454

RE: Aileen Ockwig
Augsburg College School of Social Work

Dear Dr. Weisbrod,

I am writing to you on behalf of Aileen Ockwig, who is an MSW graduate student at Augsburg College. Aileen is conducting research concerning modes of therapy with adults that have experienced attachment disorders. Aileen approached me as Co-President of the Minnesota Society for Clinical Social Work for permission to survey our members in connection with her research.

After consulting with our Society's board of directors, I am happy to say that we support Ms. Ockwig's research as being of potential value to the field and grant permission for her to survey our members as she requested. She has agreed to protect members' anonymity while conducting her research.

Sincerely,

Elizabeth W. Horton

Elizabeth W. Horton, LICSW
Co-President
Telephone 612-920-3265
Fax 612-920-6957

IMPLICATIONS OF ATTACHMENT THEORY AS IT RELATES TO THERAPEUTIC PRACTICES WITH ADULT CLIENTS.

May 15, 1997

Dear Clinical Social Worker,

I am a graduate student working toward a Masters in Social Work degree at Augsburg College in Minneapolis, MN. For my thesis, I am conducting an exploratory study regarding clinician's perspectives concerning psychotherapeutic practices, techniques, and strategies, used in therapy with adult clients who present with attachment disorders. You were selected as a possible participant because you are a member of the Society of Clinical Social Workers. This research study has been approved by and is being done in cooperation with the Society of Clinical Social Workers. Please read this form carefully.

BACKGROUND INFORMATION:

This research study is being conducted to provide me with information for my Master of Social Work thesis and to provide you with an opportunity to discuss your views regarding your therapeutic practices with adult clients who have difficulty with attachment issues.

VOLUNTARY NATURE OF THIS STUDY:

Your experiences and perspectives are important. The decision to participate in this survey is entirely at your discretion. Your decision will not effect your current or future affiliation with the Society of Clinical Social Workers or Augsburg College.

PROCEDURES AND ANONYMITY:

I am surveying all social workers who presently are members of the Society of Clinical Social Workers. Your anonymity is protected since a person not involved with the study will be mailing out the questionnaires. I do not know your name. Completed and returned questionnaires will be filed in a locked drawer in my office and will be destroyed December 1998.

RISKS AND BENEFIT OF BEING A PARTICIPANT IN THIS STUDY:

There is minimal risk to participants in this study, because the information from this interview will be used for my thesis and presented in summarized form only to members of the Society of Clinical Social Workers upon request. While there are no direct benefits to participating in this research study, this is an opportunity to report your perceptions of the therapeutic practices used with adult clients who present with attachment difficulties which may, in turn, identify future research questions and current practice information regarding therapeutic practices adult clients.

This questionnaire is a one-time commitment on your behalf and may take you approximately twenty (20) minutes to complete. Please do not write your name or any other identifying information on the questionnaire or on the return envelope. Once completed, please return this questionnaire in the enclosed self-addressed, stamped envelope as soon as possible and no later than May 30, 1997. The completion and return of the questionnaire will indicate your consent to participation in this research study as well as conclude your role in this study.

An explanation of attachment theory and what types of attachment disorders the study is addressing.

Attachment behavior is a form of behavior that results in a person attaining and maintaining proximity with another individual identified as their primary care-giver. The primary care-giver is described as someone who is able to give support whenever the person feels tired, frightened, sick and cares for the person regularly.

Secure attachment happens when an individual grows up in a supportive environment characterized by parents who are responsive to their child's attachment seeking behavior and provide a secure base for the child to explore the world around them. In psychoanalytic literature such an individual can be described as having a strong ego, able to achieve basic trust, and believe that he/she is worthy of love.

Anxious or ambivalent insecure individuals appear over dependent, immature and seek acceptance from others. When exposed to multiple stressors they are likely to develop depression, phobic behaviors, and neurotic symptoms. An anxious insecure individual's primary care-giver can be described as inconsistent, emotionally unavailable and unresponsive to the attachment seeking behavior of their child.

Insecure-Avoidant individuals often have similar familial experiences to those of persons with anxious and/or ambivalent attachments however, the avoidant clients react to the same environment in a different manner. They're distrustful of close relationships and do not rely on others for anything, because they are afraid of being rejected and have no desire to care for others.

Disorganized-Disoriented, Compulsive self reliant and Compulsive Care-giver individuals have lived with a tremendous sense of loss due to the death of their primary care-giver during childhood or live with a care-giver who demands to be taken care of by their children out of their own set of unmet childhood needs. When the primary care-giver dies the remaining parent often is so caught in his/her own grief that he/she does not allow his/her children to grieve and often is not emotionally available to his/her children. The compulsive care-giver as an adult has many close relationships and takes the role of care-giver in the many relationships without identifying his/her own needs. Basically, the compulsive caregiver believes that in order to have an affectionate bond with another person he/she has to fulfill the role of the care-giver.

Thank you in advance for considering this research study.

If you have any questions regarding this research study, please do not hesitate to contact me by pager (651) 966-3205 or Sharon Patten, Ph.D., my thesis advisor at Augsburg College, at (612) 330-1723

Thank You,

Aileen F. Ockwig
Graduate Student and Principal Investigator